

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Benefits Administration

*Inspection of
the VA Regional Office
St. Louis, Missouri*

September 7, 2017
17-02150-340

ACRONYMS

AVSCM	Assistant Veterans Service Center Manager
FY	Fiscal Year
NWQ	National Work Queue
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
SMC	Special Monthly Compensation
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
VSCM	Veterans Service Center Manager
VSR	Veterans Service Representative

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Highlights: Inspection of the VARO St. Louis, Missouri

Why We Did This Review

In May 2017, we evaluated the Department of Veterans Affairs Regional Office (VARO) in St. Louis, Missouri, to assess whether Veterans Service Center (VSC) staff accurately processed disability claims; timely and accurately processed proposed rating reductions; accurately entered claims related information; and timely and accurately responded to special controlled correspondence.

What We Found

Claims Processing—St. Louis VSC staff did not consistently process one of the two types of disability claims we reviewed. We reviewed 30 of 978 veterans' traumatic brain injury claims (3 percent) and found Rating Veterans Service Representatives (RVSR) accurately processed 29 of the 30 cases. However, RVSRs did not always process entitlement to special monthly compensation (SMC) and ancillary benefits consistent with Veterans Benefits Administration (VBA) policy.

We reviewed 30 of 46 veterans' SMC claims (65 percent) and found RVSRs incorrectly processed four cases. This resulted in 20 improper monthly payments made to two veterans, totaling approximately \$39,900. Errors occurred because staff did not see these cases frequently enough to gain familiarity on how to process them correctly and found them to be complex.

Proposed Rating Reductions—VSC staff needed to improve timeliness and accuracy in the processing of proposed rating reductions. We reviewed 30 of 325 proposed rating reduction cases (9 percent) and found staff delayed or incorrectly processed 16 of 30. Delays were due to higher prioritization of other workloads and resulted in about \$83,100 in overpayments. Inaccurate processing was due to ineffective training. Staff noted they were unaware of the proper procedures for processing rating reductions. These errors resulted in approximately \$5,300 in improper payments.

Systems Compliance—VSC staff needed to improve the accuracy of data input into the electronic systems at the time of claims establishment. We reviewed 30 of 1,136 established claims (3 percent) and found Claims Assistants and Veterans Service Representatives did not correctly establish 16 of 30 claims due to ineffective training. That training provided improper guidance regarding contention classification and oversight that did not review the issue of accuracy of data at time of claims establishment. Consequently, the potential existed for claims to be misrouted and processing to be delayed.

Special Controlled Correspondence—VSC staff needed to improve timeliness and accuracy in the processing of special controlled correspondence. We reviewed 30 of 476 special controlled correspondence (6 percent). Staff incorrectly processed 25 of the 30 cases due to insufficient staffing and a lack of training on how to process special controlled correspondence. As a result,

congressional staff were not timely made aware of the status of cases about which they had inquired, and VBA staff would not be able to review issues pertaining to timeliness and accuracy of special controlled correspondence in the veterans' electronic claims folders.

What We Recommended

We recommended the VARO Director implement plans to provide refresher training for SMC, rating reductions, and special controlled correspondence. We also recommended the Director monitor the effectiveness of recent training for claims establishment procedures. Finally we recommended the Director ensure SMC rating decisions receive a second signature review by a designated subject matter expert for processing, ensure benefit reductions are processed at the end of due process, and allocate sufficient resources to process special controlled correspondence.

Agency Comments

The VARO Director concurred with our recommendations. Management's planned actions are responsive and we will follow up as required.



LARRY M. REINKEMEYER
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INTRODUCTION

Objectives

The Benefits Inspection Program is part of the VA OIG’s efforts to ensure our nation’s veterans receive timely and accurate benefits and services. We conduct onsite inspections at randomly selected VA Regional Offices (VARO) to assess their effectiveness. In FY 2017, we looked at four mission operations—Disability Claims Processing, Management Controls, Data Integrity, and Public Contact. We identify key objectives and risks within each operation or VARO program responsibility. In FY 2017, our objectives were to assess the VARO’s effectiveness in:

- Disability claims processing by determining whether Veteran Service Center (VSC) staff accurately processed traumatic brain injury (TBI) claims and claims related to special monthly compensation (SMC) and ancillary benefits.
- Management controls by determining whether VSC staff timely and accurately processed proposed rating reductions.
- Data integrity by determining whether VSC staff accurately input claim and claimant information into the electronic systems.
- Public contact by determining whether VSC staff timely and accurately processed special controlled correspondences.

Where we identify potential procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. Errors that affect benefits have a measurable monetary impact on veterans’ benefits. Errors that have the potential to affect benefits are those that either had no immediate effect on benefits or had insufficient evidence to determine the effect on benefits.

St. Louis VA Regional Office

As of May 2017, the Veterans Benefits Administration (VBA) reported the St. Louis VARO had a staffing level of 760 full-time employees; the VARO was authorized to have 826 employees. Of this total, the VSC had 245 employees assigned; the VSC was authorized 269 employees. In May 2017, VBA reported the St. Louis VARO completed 13,594 compensation claims—averaging four issues¹ per claim.

¹ Under M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section B, *Determining the Issues*, “issues” are disabilities and benefits.

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Finding 1

St. Louis VSC Staff Generally Processed TBI Claims Correctly but Needed to Improve Accuracy In Processing Claims Related to SMC and Ancillary Benefits

Rating Veterans Service Representatives (RVSR) generally processed TBI claims correctly. However, they did not always process entitlement to SMC and ancillary benefits consistent with VBA policy. Generally, the errors associated with processing SMC were due to staff's unfamiliarity with processing these claims, as they did not work them on a frequent basis. Overall, RVSRs correctly processed 55 of the 60 disability claims (92 percent) we reviewed. Two of the errors we identified resulted in 20 improper monthly payments to two veterans totaling approximately \$39,900² as of April 2017.

Table 1 reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the VARO. We sampled claims related only to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims or the overall accuracy rate at this VARO.

Table 1. St. Louis VARO Disability Claims Processing Accuracy

Type of Claim	Reviewed	Veterans' Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total
TBI	30	0	1	1
SMC and Ancillary Benefits	30	2	2	4
Total	60	2	3	5

Source: VA OIG analysis of the VBA's TBI disability claims completed from September 1, 2016 through February 28, 2017, and SMC and ancillary benefits claims completed from March 1, 2016 through February 28, 2017.

² All calculations in this report have been rounded when applicable.

**VBA Policy
Related to TBI
Claims**

VBA defines a TBI event as a traumatically induced structural injury or a physiological disruption of brain function resulting from an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral/emotional.³ VBA policy requires staff to evaluate these residual disabilities. VBA policy states that all rating decisions that address TBI as an issue must only be worked and reviewed by an RVSR or Decision Review Officer (DRO) who has completed the required TBI training. Rating decisions for TBI require two signatures until the decision-maker has demonstrated an accuracy rate of 90 percent or greater, based on the VARO's review of at least 10 TBI decisions.⁴

VBA policy requires that one of the following specialists must make the initial diagnosis of TBI: psychiatrists, neurosurgeons, or neurologists.⁵ A generalist clinician who has successfully completed the required TBI training may conduct a TBI examination if the diagnosis is of record and was established by one of the aforementioned specialty providers.⁶

**Review of TBI
Claims**

We randomly selected and reviewed 30 of 978 veterans' TBI claims (3 percent) completed from September 1, 2016 through February 28, 2017 to determine whether VSC staff decided them according to Federal regulations. For example, we checked to see if VSC staff obtained an initial TBI medical examination, as required.⁷

RVSRs correctly processed 29 of 30 TBI claims (97 percent)—the single inaccuracy had the potential to affect a veteran's benefits. Our review of initial TBI examinations found no improper diagnoses of TBI. The Assistant Veterans Service Center Manager (AVSCM) concurred with the one error we identified, which involved an RVSR denying service connection for TBI without ordering a medical examination as required.⁸ Neither VSC staff nor we can determine if the denial of service connection for TBI was correct without medical examination results. Because RVSRs processed 29 of the 30 TBI claims correctly, we made no recommendation for improvement in this area.

³ M21-1 Adjudication Procedures Manual, Part III, subpart iv, Chapter 4, Section G, Topic 2, *TBI*.

⁴ *Ibid.*

⁵ M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 3, Section D, Topic 2, *Examination Report Requirements*.

⁶ *Ibid.*

⁷ 38 CFR §3.159(c)(4). *Department of Veterans Affairs assistance in developing claims*.

⁸ *Ibid.*

*Previous VA
OIG
Inspection
Results*

In our previous report, *Inspection of VA Regional Office, St. Louis, Missouri* (Report No. 14-01497-188, July 24, 2014), we identified four TBI claims available for our review that VSC staff incorrectly processed. The errors were due to staff not assigning cases to a specialized team as required. We recommended the VARO Director implement a plan to ensure staff assigned TBI claims to the specialized teams. Management noted they implemented a daily prioritization tracker to locate special claims like TBI cases and route them to the specialized team as required.

*VBA Policy
Related to SMC
and Ancillary
Benefits*

VBA assigns SMC to recognize the severity of certain disabilities or combinations of disabilities by adding an additional compensation to the basic rate of payment where the basic rate is not sufficient for the level of disability present. SMC represents payments for “quality of life” issues such as the loss of an eye or limb, or the need to rely on others for daily life activities, like bathing or eating. Ancillary benefits are secondary benefits that are considered when evaluating claims for compensation, which include eligibility for educational,⁹ automobile,¹⁰ and housing benefits.¹¹

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement.¹² VBA policy also states all rating decisions involving SMC above a specified level require a second signature.¹³

In our report, *Review of VBA’s Special Monthly Compensation Housebound Benefits* (Report No. 15-02707-277, September 29, 2016), we reviewed SMC housebound benefits. Our Benefits Inspection reports reviewed a higher level of SMC that included payment rates related to disabilities such as loss of limbs, loss of eye sight, and paralysis. These reviews did not overlap because this review involved different types of SMC that cannot be granted simultaneously with SMC housebound benefits.

*Review of SMC
and Ancillary
Benefit Claims*

We randomly selected and reviewed 30 of 46 veterans’ claims (65 percent) involving SMC and ancillary benefits completed from March 1, 2016 through February 28, 2017. We examined whether VSC staff accurately decided entitlement to SMC and ancillary benefits associated with anatomical loss, loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse. We found four of 30 veterans’ claims

⁹ 38 CFR §3.807, Dependents’ Educational Assistance, provides education benefits for the spouse and children of eligible veterans.

¹⁰ *Ibid.*, §3.808, Automobiles or Other Conveyances and Adaptive Equipment, provides eligible veterans payments toward the purchase of an automobile or other special equipment or assistive devices such as power seats.

¹¹ *Ibid.*, §3.809a, Special Home Adaptation (SHA) Grants, provide eligible veterans the purchase or construction of barrier-free homes or remodeling an existing home to accommodate disabilities.

¹² M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section B, Topic 2, *Considering Subordinate Issues and Ancillary Benefits*.

¹³ *Ibid.*, Section D, Topic 7, *Signature*.

contained errors. Two errors affected veterans' benefits and resulted in improper payments totaling approximately \$39,900. These errors represented 20 improper monthly payments from July 1, 2015 to November 1, 2016. We provided the AVSCM with the specifics of the claims and asked for a review. The AVSCM concurred with the errors.

The two errors that affected veterans' benefits both involved RVSRs assigning incorrect levels of SMC. In the case with the most significant improper payment, an RVSR incorrectly granted SMC for aid and attendance. As a result, the veteran was overpaid approximately \$27,600 over a period of eight months.

The other case with improper payments involved an RVSR assigning an incorrect effective date for bilateral blindness and an incorrect level of SMC for the blindness. As a result of the incorrect effective date, the veteran was overpaid approximately \$10,100. As a result of the incorrect level of SMC, the veteran was underpaid approximately \$2,200.

The two remaining errors had the potential to affect veterans' benefits. In one of these cases an RVSR assigned a level of SMC without a medical examination to determine complications of a veteran's service-connected Amyotrophic Lateral Sclerosis. As a result, the level of SMC assigned for the veteran's disabilities may have been incorrect.

Generally, the errors involved RVSRs assigning an incorrect level of SMC. RVSRs interviewed noted they found SMC cases to be complex and difficult to process, as they don't see them on a frequent basis. RVSRs noted training was helpful, however they found it difficult to retain training knowledge as SMC cases were not seen routinely. Our review determined VSC staff processed approximately 50 SMC cases involving anatomical loss, loss of use of two or more extremities, or bilateral blindness over the course of an entire year, confirming a small population of SMC cases at this level. Additionally, one RVSR who rated the majority of the SMC cases in our sample processed them all correctly. The RVSR attributed SMC accuracy to working these cases on a more frequent basis.

*Previous VA
OIG
Inspection
Results*

In our previous report, *Inspection of VA Regional Office, St. Louis, Missouri* (Report No. 14-01497-188, July 24, 2014), we identified eight errors related to SMC and ancillary benefits out of the 30 claims reviewed. We determined staff were not forwarding SMC cases to a specialized team as required and that local oversight had not been conducted for the eight errors. We recommended the VARO Director clarify which SMC cases require processing by a specialized team. We also recommended the Director develop and implement a plan to ensure compliance with local policy requiring that staff assigned to a specialized team process SMC claims. Further, we recommended the Director implement a plan to ensure that staff comply with local policy requiring DROs to conduct second signature

reviews of SMC claims. The VARO Director concurred with our recommendations and stated they planned to update the VARO's workload management plan to define which SMC claims require processing by a specialized team. The Director also notified staff that DROs were required to conduct oversight of SMC claims. Since we found fewer errors involving SMC evaluations, the VARO's responses to our previous recommendation appear to have been effective.

Recommendations

1. We recommended the St. Louis VA Regional Office Director implement a plan to provide refresher training on Special Monthly Compensation and monitor the effectiveness of that training.
2. We recommended the St. Louis VA Regional Office Director implement a plan to ensure Special Monthly Compensation rating decisions receive a second signature review by a designated subject matter expert for processing.

Management Comments

The VARO Director concurred with our findings and recommendations. The Director stated the VSC will complete SMC refresher training for all RVSRs and DROs with a target completed date of October 13, 2017. Additionally, the VSC will have rating decisions that involve high levels of SMC reviewed and second signed by designated subject matter experts.

OIG Response

The VARO Director's comments and actions are responsive to the recommendations. We will follow up as required.

II. Management Controls

Finding 2

St. Louis VSC Staff Needed to Improve Accuracy and Timeliness In Processing Proposed Rating Reductions

We randomly selected and reviewed 30 out of 325 cases (9 percent) where benefits were proposed to be reduced to determine whether VSC staff accurately and timely processed them. Overall, 16 of the 30 cases we reviewed contained inaccuracies or delays. All 16 cases involved delays, and five cases also contained accuracy errors. Of these, 15 affected veterans' benefits and resulted in overpayments totaling approximately \$86,800 and underpayments totaling approximately \$1,600, representing 95 improper monthly payments from December 1, 2015 to April 1, 2017. Per manual guidance, VBA does not recover these overpayments because the delays were due to VA administrative errors.¹⁴ The remaining case had the potential to affect benefits.

Processing delays occurred due to the Veterans Service Center Manager (VSCM) and Supervisory Veterans Service Representative not prioritizing these cases highly enough to ensure action would be taken on the date the due process notice period expired. Accuracy errors were due to ineffective training, as Veterans Service Representatives (VSR) were not aware of the proper procedure for processing reductions.

VBA Policy Related to Proposed Rating Reductions

Federal regulation provides for compensation payments to veterans for conditions they incurred or aggravated during military service.¹⁵ The amount of monthly compensation to which a veteran is entitled could change because his or her service-connected disability could improve. Improper payments associated with benefits reductions generally occur when beneficiaries receive payments to which they are not entitled.¹⁶ Such instances are attributable to VSC staff not taking the actions required to ensure veterans receive correct payments for their current levels of disability.

When the VARO obtains evidence that demonstrates a disability has improved, and the lower evaluation would result in a reduction or discontinuance of current compensation payments, VSRs must inform the beneficiary of the proposed reduction in benefits.¹⁷ In order to provide beneficiaries due process, VBA allows 60 days for the veteran to submit additional evidence to show that compensation payments should continue at their present level.¹⁸ If the veteran does not provide additional evidence within that period, an RVSR may make a final determination to reduce or

¹⁴ M21-1 MR Adjudications Procedures Manual, Part III, Subpart v, Chapter 1, Section I, Topic 3, *Consideration of the Cause of Erroneous Benefits*, and 38 CFR §3.500.

¹⁵ 38 CFR §3.303. *Principles relating to service connection.*

¹⁶ Public Law 107-300.

¹⁷ *Ibid.*, §3.103. *Procedural due process and appellate rights.*

¹⁸ 38 CFR §3.105. *Revision of decisions.*

discontinue the benefit¹⁹ beginning on the 65th day following notice of the proposed action.²⁰

On April 3, 2014²¹ and again on July 5, 2015,²² VBA leadership modified its policy regarding the processing of claims requiring benefits reductions. The current policy no longer includes the requirement for VSC staff to take “immediate action” to process these reductions. VBA noted this change was made to avoid implying the next action on a proposed reduction must be immediate. VBA policy also no longer includes a measurable standard for VSC staff to make final determinations to reduce benefits following expiration of the due process period. In lieu of merely removing the vague standard, VBA should have provided clearer guidance that ensures sound financial stewardship of these monetary benefits.

**Review of Cases
to Assess
Accuracy**

We randomly selected and reviewed 30 of 325 cases (9 percent) completed from December 1, 2016 through February 28, 2017 where benefits were proposed to be reduced by rating decisions. RVSRs and VSRs inaccurately processed five of 30 cases involving benefits reductions (17 percent). All errors involved RVSRs and VSRs assigning incorrect effective dates for reduced or discontinued evaluations. Four errors affected veterans’ benefits and resulted in improper payments totaling approximately \$5,300.

In the case with the most significant improper payment, an RVSR assigned an incorrect effective date of May 1, 2017 for a disability reduction. According to federal regulation, the reduction should have been February 1, 2017, the date last paid at the time of the rating decision.²³ As a result of this processing inaccuracy, VA overpaid the veteran approximately \$2,300 over a two-month period at the time of our review, April 2017.

In the case that had the potential to affect a veteran’s benefits, an RVSR severed service connection for a veteran’s right shoulder condition effective May 1, 2017. However, the rating decision was processed incorrectly, as a VSR made the severance effective June 1, 2017. The veteran could receive future improper benefit payments as a result of the incorrect date of reduction.

Generally, the accuracy errors were due to ineffective training. The VSRs interviewed noted they could not recall the last time they received training on reduction procedures, and as a result they were not sure of the proper way to process final reductions. Training records noted the VSRs’ most recent

¹⁹ *Ibid.*

²⁰ M21-4 Appendix B, Section II, *End Products - Compensation, Pension, and Fiduciary Operations.*

²¹ M21-1MR Adjudications Procedures Manual, Part I, Chapter 2, Section B, Topic 7, *Establishing and Monitoring Controls.*

²² *Ibid.*, Section C, Topic 2, *Responding to the Beneficiary.*

²³ 38 CFR §3.655(c). *Failure to report for Department of Veterans Affairs examination.*

training on this topic occurred more than a year prior to the errors. The training coordinator stated it was a challenge to find staff who could effectively provide training, as subject matter experts stated they instead needed to focus on meeting work production goals.

**Review of Cases
to Assess
Processing
Timeliness**

Processing delays that required rating decisions to reduce benefits occurred in 16 of 30 claims (53 percent). We considered cases to have delays when RVSRs did not process them on the 65th day following notice of the proposed action, and the resulting effective date of reduction was impacted by at least one month. For the 16 cases with processing delays, the delays had resulted in an average of nearly six monthly overpayments at the time we began our review.

The most significant improper payment occurred when an RVSR proposed to reduce a veteran's evaluation for prostate cancer, based on medical evidence showing improvement. The due process period expired on February 18, 2016 without the veteran providing additional evidence. However, an RVSR did not take final action to reduce benefits until December 1, 2016. As a result, VA overpaid the veteran approximately \$27,800 over a period of 10 months.

One of the errors had potential to affect a veteran's benefits. In this case, an RVSR proposed to reduce a veteran's evaluations for Hodgkin's disease, based on medical evidence showing improvement. The due process period expired on January 25, 2017 without the veteran providing additional evidence. However, an RVSR did not take final action to reduce benefits until February 17, 2017. The reduction in the veteran's benefits would have been effective May 1, 2017. As a result of the delayed final rating decision to reduce benefits, the veteran could receive future improper benefit payments.

We provided the details on the delays and accuracy errors that affected benefits, or had the potential to affect benefits, to the AVSCM for appropriate action. The AVSCM agreed with our accuracy errors but did not agree with the 16 delay errors we identified, noting that policy does not provide a specific timeframe for completion of the final rating decision to reduce benefits. Prior to the policy change in April 2014, VBA policy had required that maturing due process cases were to be processed immediately on the 65th day to minimize overpayments. An interview with VBA Compensation Service staff noted the policy was changed as it was generally felt that workload management decisions were under the purview of VARO management and Office of Field Operations. St. Louis VARO management agreed that if RVSRs had taken action at the expiration of the due process period, \$83,100 would not have been paid for medical conditions shown to have improved.

Generally, these processing delays occurred because VARO management did not prioritize these cases high enough to ensure action would be taken on the date the due process period expired. Interviews with VSC staff, a Supervisory Veterans Service Representative, and the VSCM confirmed that rating reduction cases are a lower priority compared to other work directed by VBA's Central Office. As a result of the processing delays, veterans received their current benefits payment amounts despite objective medical evidence showing their medical conditions had improved to the point of warranting a reduction in their benefit entitlement. Without a timeliness standard to measure the workload, VBA will continue to provide unsound financial stewardship of veterans' monetary benefits and fail to minimize improper payments.

*Previous VA
OIG
Inspection
Results*

In our previous report, *Inspection of VA Regional Office, St. Louis, Missouri* (Report No. 14-01497-188, July 24, 2014), we identified seven errors involving proposed rating reductions out of the 30 claims reviewed. We determined that other workload priorities prevented staff from taking immediate action on benefits reductions. We recommended the VARO Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans. However, the Director's response noted timely actions on benefits reduction cases are dependent on competing workload demands and adherence to a national workload prioritization strategy.

Recommendations

3. We recommended the St. Louis VA Regional Office Director implement a training plan, conducted by qualified staff, on the proper processing of rating reductions, and monitor the effectiveness of that training.
4. We recommended the St. Louis VA Regional Office Director implement a plan to ensure rating reduction cases are processed at the end of the due process time period to minimize overpayments.

*Management
Comments*

The VARO Director concurred with our findings and recommendations. The Director stated the VSC will complete training on the processing of rating reductions for VSR assigned to process this work. The target date of completion is October 13, 2017.

In addition, the Director reported that as of April 9, 2017 all VAROs receive daily actionable due process work that must be completed within five days.

*OIG
Response*

The VARO Director's comments and actions are responsive to the recommendations, and the VARO has requested closure of Recommendation 4. Based on the information provided, we consider this recommendation closed. We will follow up as required.

III. Data Integrity

Finding 3

St. Louis VSC Staff Needed to Improve the Accuracy of Information Input Into the Electronic Systems at the Time of Claims Establishment

We randomly selected and reviewed 30 out of 1,136 pending rating claims (3 percent) from VBA's Corporate Database to determine whether VSC staff accurately input claim and claimant information into the electronic systems at the time of claim establishment. In 16 of the 30 claims we reviewed, Claims Assistants, VSRs, and a Supervisory Veterans Service Representative did not enter accurate and complete information in the electronic systems when the claims were established. These errors were due to ineffective training and oversight. VSC staff noted that the training they received provided improper guidance and that VBA does not have a nationally focused training program for Claims Assistants. Consequently, these claims could have been misrouted in the National Work Queue (NWQ), delayed claims processing, and affected data integrity, thus misrepresenting the VARO's performance measurements.

VBA Policy Related to Data Integrity

VBA relies on data input into electronic systems to accurately manage and report their workload to stakeholders and to properly route claims within their electronic workload management tool, the NWQ. The NWQ centrally manages the national claims workload by prioritizing and distributing claims across VBA's network of VAROs using rules that assign workload based on certain claimant and claim information within the electronic systems.²⁴ The Veterans Benefits Management System is an electronic processing system the NWQ uses to distribute work.²⁵ Because the NWQ relies on the accuracy of data, claims misidentified or mislabeled at time of claims establishment can result in improper routing and therefore lead to untimely processing of claims and delays in veterans' benefits. In addition, if not controlled by accuracy reviews at the time of the claim establishment, personally identifiable information could be disclosed without authorization.

Initial claims routing begins at the time of claims establishment. Claims Assistants or VSRs must input claim and claimant information into the electronic systems to ensure compliance with systems processing. Table 2 reflects nine claims establishment terms.

²⁴ Department of Veterans Affairs, Veterans Benefits Administration, National Work Queue, Phase 1 Playbook.

²⁵ *Ibid.*

Table 2. Claims Establishment Terms

Term	Definition
Date of Claim	Earliest date the claim or information is received in any VA facility
End Product	The end product system is the primary workload monitoring and management tool for the VSC
Claim Label	A more specific description of the claim type that a corresponding end product represents
Claimant Address	Mailing address provided by the claimant
Claimant Direct Deposit	Payment routing information provided by the claimant
Power of Attorney	An accredited representative of a service organization, agent, non-licensed individual, or attorney representative chosen by the claimant to represent him or her
Corporate Flash Indicator	Claimant-specific indicators which can represent an attribute, fact, or status that is unlikely to change
Special Issue Indicator	Claim-specific indicators and can represent a certain claim type, disability or disease, or other special notation that is only relevant to a particular claim
Claimed Issue with Classification	Specifies the claimed issue and its medical classification

Source: VA OIG presentation of definitions from VBA's M21-1 and M21-4

Systems Compliance

We randomly selected and reviewed 30 of 1,136 claims (3 percent) established in February 2017 that were pending rating decisions as of March 3, 2017. In 16 of the 30 claims we reviewed (53 percent), Claims Assistants, VSRs, and a Supervisory Veterans Service Representative did not enter accurate and complete information in the electronic systems at time of claim establishment. The AVSCM concurred with the errors we identified.

In eight of the 16 cases with errors (50 percent), Claims Assistants and a VSR did not establish correct contentions and contention classifications—this was the most frequent establishment error type we found. For example, in three of the eight cases veterans claimed service connection for tinnitus. However, Claims Assistants incorrectly listed the contention classification for the tinnitus claims as “Ear Disease and Other Senses Organs,” rather than the proper medical classification of “Hearing Loss.” VBA policy states contention classification and medical fields are required components when entering a contention.²⁶ Selection of the appropriate contention classification will drive the selection of medical exams once exam automation

²⁶ M21-1 Adjudications Procedures Manual, Part III, Subpart iii, Chapter 1, Section D, Topic 2, *Utilizing Contentions and Special Issue Indicators Associated with Claimed Issues*.

functionality has been implemented. Furthermore, if the contention classification is incorrectly selected, it will send the incorrect data to the examiner and may cause the scheduling request to be returned with clarification requests. This could potentially lead to processing delays for veterans' claims.

Generally, the processing errors occurred because staff that established claims were not using a training job aid that provided proper classifications procedures. VSC staff noted they disregarded the job aid and instead relied on previous improper guidance that told them an incorrect way to classify disability claims. The VSCM stated VBA did not have a nationally focused training program for Claims Assistants, and thought one would be beneficial. Following our notification of errors to the AVSCM, training was conducted for Claims Assistants at the VARO that discussed the proper way to establish claims with emphasis on contention classifications.

Claims establishment errors could have been mitigated if more effective oversight of the claims establishment process had been in place. There was no requirement that oversight be performed at the time claims are established. Management, including a Supervisory Veterans Service Representative and the VSCM, stated oversight was performed randomly the month following claims establishment. Therefore, the quality reviewer was unable to determine whether Claims Assistants or VSRs initially established the claim correctly. As a result of the ineffective training and oversight, there was the potential to misroute claims in the NWQ, delay claims processing, and misrepresent the VARO's performance measurements.

Recommendations

5. We recommended the St. Louis VA Regional Office Director implement a plan to monitor the effectiveness of recent training for claims establishment.
6. We recommended the St. Louis VA Regional Office Director implement a plan to ensure data input at the time of claims establishment is reviewed for accuracy.

Management Comments

The VARO Director concurred with our findings and recommendations. The Director noted training for establishing claims has been conducted for Claims Assistants, and claims establishment and training needs are now evaluated annually in the Systematic Analysis of Operations (SAO) for Quality of Centralized Mail Activities. In addition, beginning in September 2017, the VSC will conduct same-day claims establishment reviews to identify error trends. Finally, the Intake Processing Center supervisor or Intake Analyst will conduct monthly quality reviews to track accuracy and error trends for additional training as needed.

**OIG
Response**

The VARO Director's comments and actions are responsive to the recommendations. We will follow up as required.

IV. Public Contact

Finding 4

St. Louis VSC Staff Needed to Improve the Accuracy and Timeliness Associated With Processing Special Controlled Correspondence

We randomly selected and reviewed 30 of 476 special controlled correspondence cases (6 percent) to determine whether Congressional Liaisons timely and accurately processed them. Overall, 25 of the 30 cases we reviewed contained delays or inaccuracies. All 25 cases involved inaccurate processing, and 22 cases also contained untimely responses. The errors were due to insufficient staffing and staff not receiving training on certain procedures. As a result of the inaccuracies, VBA staff would not be able to review issues pertaining to timeliness and accuracy of special controlled correspondence in the veterans' electronic claims folders. As a result of the delays, congressional staff were not timely made aware of the status of cases about which they had inquired.

VBA Policy Related to Special Controlled Correspondence

Special controlled correspondence is mail that requires expedited processing, control, and response. Examples of special correspondence include mail received from the White House, members of Congress, national headquarters of service organizations, and private attorneys. VBA policy requires the VARO Director or the VSC manager to establish a specific tracking code for all special correspondence.²⁷ Staff are required to send an acknowledgement letter within five business days after receipt in the VARO.²⁸

According to VBA policy, all correspondence generated by VA must provide complete, accurate, and understandable information.²⁹ In addition, VSC staff must file these documents either in a claims folder or upload them into an electronic folder.³⁰

Review of VARO Processing of Special Correspondences to Assess Accuracy

We randomly selected and reviewed 30 of 476 special controlled correspondence (6 percent) completed from December 1, 2016 through February 28, 2017. Congressional Liaisons incorrectly processed 25 of the 30 special controlled correspondence inquiries reviewed. In all 25 cases, Congressional Liaisons did not properly control the special controlled correspondence. For example, in one case an email inquiry was received from a congressional representative on August 4, 2016. An end product was established and removed on August 4, 2016 and February 21, 2017, despite the final response letter not being sent until March 20, 2017. As a result,

²⁷ M21-4 Appendix B, Section II, *End Products - Compensation, Pension, and Fiduciary Operations*.

²⁸ M27-1 Benefits Assistance Service Procedures, Part I, Chapter 5, Topic 3, *Acknowledging Correspondence*.

²⁹ *Ibid.*, Topic 1, *General Guidance for Processing Correspondence*.

³⁰ M21-1 Adjudication Procedures Manual, Part III, Subpart ii, Chapter 1, Section B, Topic 2, *Handling Incoming Mail*.

workload measurement for special controlled correspondence, including number of pending claims, number of days a claim was pending, and number of days to complete claims, was misrepresented.

In addition, Congressional Liaisons did not upload congressional inquiries or responses to and from congressional staff into veterans' electronic claims folders in five cases. As a result, VBA staff would not be able to review issues pertaining to timeliness and accuracy of these documents in the veterans' electronic claims folders.

The AVSCM concurred with the errors we identified. Generally, inaccurate processing occurred because staff were not aware of current VBA policy and they were processing the inquiries using local guidance that did not reference control procedures as noted in VBA policy. Interviews with VSC staff revealed there was no formal training related to special controlled correspondence. VBA does not have a training course for processing special controlled correspondence. Staff members assigned to review and respond to special controlled correspondence only received on-the-job training and were not familiar with current procedures relating to the proper handling of special controlled correspondence.

***Review of
VARO
Processing of
Special
Correspondences
to Assess
Timeliness***

In 22 of 30 inquiries reviewed (73 percent), Congressional Liaisons did not send an acknowledgement letter within five business days as required. In these cases, evidence in the file showed Congressional Liaisons provided responses to inquiries from congressional staff from 15 to 154 business days after receipt. Additionally, for five cases we were unable to determine if Congressional Liaisons responded within five business days, as the congressional inquiry was not associated with the claims file as required. Congressional Liaisons should have acknowledged the correspondence within five business days and ensured these responses were filed in veterans' electronic claims folders, as required.

The AVSCM concurred with the errors we identified. The delays in processing responses to congressional inquiries resulted because there was only one Congressional Liaison assigned in a full-time position to work on special controlled correspondence claims. The VSCM acknowledged staffing resources were limited and chose not to assign a second full-time Congressional Liaison because processing compensation claims was a higher priority. An AVSCM also acknowledged the challenges in processing inquiries timely and noted that timeliness should improve, as some of the backlog would be assigned to appeals staff based on a recent change in VBA policy concerning appeal workloads.

Recommendations

7. We recommended the St. Louis VA Regional Office Director implement a training plan on how to properly process special controlled correspondence, and monitor the effectiveness of that training.
8. We recommended the St. Louis VA Regional Office Director allocate resources to process special controlled correspondence to ensure timely responses.

Management Comments

The VARO Director concurred with our findings and recommendations. The Director reported training on correspondence procedures was conducted in December 2016, and the AVSCM will conduct weekly reviews of special correspondence processed in the VSC. In addition, an annual analysis of special controlled correspondence will be addressed in the Public Contact and Outreach SAO and by the St. Louis Director's Office in the Prestige Correspondence SAO.

The Director noted from August 2016 to July 2017, an analyst was detailed part-time to assist the full time Congressional analyst. Finally, as of May 2017, Appeals staff are processing all Appeals-related inquiries.

OIG Response

The VARO Director's comments and actions are responsive to the recommendations, and the VARO has requested closure of Recommendation 8. Based on the information provided we consider this recommendation closed. We will follow up as required.

Appendix A Scope and Methodology

Scope and Methodology

In May 2017, we evaluated the St. Louis VARO to see how well it provides services to veterans and processes disability claims.

We reviewed selected management, claims processing, and administrative activities to evaluate compliance with VBA policies regarding benefits delivery and nonmedical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders. Prior to conducting our onsite inspection, we coordinated with VA OIG criminal investigators to provide a briefing designed to alert VARO staff to the indicators of fraud in claims processing.

We randomly selected and reviewed 30 of 978 veterans' disability claims related to TBI (3 percent) that the VARO completed from September 1, 2016 through February 28, 2017. We randomly selected and reviewed 30 of 46 veterans' claims involving entitlement to SMC and related ancillary benefits (65 percent) completed by VARO staff from March 1, 2016 through February 28, 2017. In addition, we randomly selected and reviewed 30 of 325 proposed rating reductions (9 percent) completed from December 1, 2016 through February 28, 2017. Furthermore, we randomly selected and reviewed 30 of 476 special controlled correspondence inquiries (6 percent) that the VARO received and responded to from December 1, 2016 through February 28, 2017. Finally, we randomly selected and reviewed 30 of 1,136 claims (3 percent) VARO staff established in the electronic record for systems compliance in February 2017.³¹

Data Reliability

We used computer-processed data from the Corporate Data Warehouse. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. We also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the 150 claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders reviewed in conjunction with our inspection of the VARO did not disclose any problems with data reliability.

³¹ During the inspection, while determining our sample size of 30 claims, we determined some claims were outside of the scope of our review; therefore, we removed these claims from the universe of claims.

***Inspection
Standards***

We conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix B Management Comments

Department of Veterans Affairs Memorandum

Date: August 15, 2017

From: Director, VA Regional Office, St. Louis, Missouri (331/00)

Subj: Response to Draft Report, Inspection of VA Regional Office St. Louis, Missouri (Project Number 2017-02150-SD-0085)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Attached are the St. Louis VARO's comments on the OIG Draft Report: Inspection of the VA Regional Office, St. Louis, Missouri.

2. Questions may be referred to Ms. Mitzi Marsh, Director, (314) 253-4310, or Mr. Gary Moore, Veterans Service Center Manager, (314)253-4370.

(Original signed by:)

MITZI MARSH
Director

Attachment

Comments on Draft Report
OIG Office of Audits and Evaluations
Benefits Inspection of the St. Louis Regional Office

Recommendation 1: We recommended the St. Louis VA Regional Office Director implement a plan to provide refresher training on Special Monthly Compensation and monitor the effectiveness of that training.

St. Louis Response: Concur with recommendation.

The St. Louis VA Regional Office (RO) Veterans Service Center (VSC) will complete Special Monthly Compensation refresher training for all Rating Veteran Service Representatives and Decision Review Officers. Target completion date: October 13, 2017.

Recommendation 2: We recommended the St. Louis VA Regional Office Director implement a plan to ensure Special Monthly Compensation rating decisions receive a second signature review by a designated subject matter expert for processing.

St. Louis Response: Concur with recommendation.

The St. Louis VA Regional Office concurs that rating decisions with SMC levels higher than (L) will be reviewed and second signed by designated subject matter experts. All Rating Veterans Service Representatives are trained to rate Special Monthly Compensation. In accordance with M21-1 III.iv.6.D.7.d, all Special Monthly Compensation claims at a rate greater than SMC (L) require review and second-signature. The St. Louis VA Regional Office has determined second signature on these claims will be completed by a Decision Review Officer or a Rating Quality Review Specialist. The St. Louis RO requests closure of this recommendation.

Recommendation 3: We recommended the St. Louis VA Regional Office Director implement a training plan, conducted by qualified staff, on the proper processing of rating reductions, and monitor the effectiveness of that training.

St. Louis Response: Concur with recommendation.

The St. Louis VSC will complete training on the processing of rating reductions for all Veteran Service Representatives assigned to process rating reductions. Target completion date: October 13, 2017

Recommendation 4: We recommended the St. Louis VA Regional Office Director implement a plan to ensure rating reduction cases are processed at the end of the due process time period to minimize overpayments.

St. Louis Response: Concur in principle.

VBA provides oversight and prioritization of proposed rating reduction cases at the national level. As of April 9, 2017, all Regional Offices receive a daily distribution of actionable due process work that is either priority - homeless, terminally ill, etc. - or our oldest pending claims. Nationally, Regional Offices are held to a standard that all work must be completed on a claim that is distributed to them within five days. Regional and District Office leadership, as well as the Office of Field Operations, routinely monitor stations performance related to the five day Time In Queue (TIQ) standard. Since NWQ began managing distribution of EP 600s (due process EPs), timeliness of these claims has improved by 30 days.

VBA will continue to monitor the improvements in EP 600 timeliness and make prioritization adjustments as necessary. VBA requests closure of this recommendation.

Recommendation 5: We recommended the St. Louis VA Regional Office Director implement a plan to monitor the effectiveness of recent training for claims establishment.

St. Louis Response: Concur with recommendation.

As noted in the report, following OIG's notification of errors to the Assistant Veterans Service Center Manager (AVSCM), training was conducted for Claims Assistants (CAs) that discussed the proper way to establish claims, with emphasis on contention classifications. Additional training related to claims establishment (CEST) was conducted on February 9, 2017 (2.5 hours), June 20, 2017 (1.75 hours) and July 11, 2017 (1 hour).

The VSC's Intake Processing Center (IPC) supervisor and Intake Analyst conduct quality reviews monthly on the accuracy of CEST processing by each CA on the team, and will continue evaluating accuracy and error trends for focused CA training on a periodic and as-needed basis.

Claims establishment and training needs are also now evaluated annually in the Systematic Analysis of Operations (SAO) for Quality of Centralized Mail Activities, per M21-4 5.04.d. The St. Louis RO requests closure of this recommendation.

Recommendation 6: We recommended the St. Louis VA Regional Office Director implement a plan to ensure data input at the time of claims establishment is reviewed for accuracy.

St. Louis Response: Concur with recommendation.

Beginning in September 2017, St. Louis VSC will implement same-day, non-punitive claims establishment reviews for quality review and training purposes (similar to "In Process Reviews" formalized for other VSC positions). The reviews are to be conducted by an IPC supervisor or Intake Analyst, and logged in a spreadsheet for tracking and analysis. Any error trends noted during these reviews will be considered for team or division-wide training.

Recommendation 7: We recommended the St. Louis VA Regional Office Director implement a training plan on how to properly process special controlled correspondence, and monitor the effectiveness of that training.

St. Louis Response: Concur with recommendation.

Training on Benefits Assistance Service (BAS) correspondence procedures was conducted in December 2016, and will be provided for any staff who participate in special controlled correspondence activities. The AVSCM overseeing the Congressional Analyst staff conducts weekly reviews and spot checks of special correspondence processed in the VSC, to include review of control procedures and upload activity. Feedback and refresher training is provided if a deficiency is noted.

Annual analysis of special controlled correspondence is also completed by the VSC in the Public Contact and Outreach SAO, M27-1 IV.3.b., and by the St. Louis Director's Office in the Prestige Correspondence SAO. The St. Louis RO requests closure of this recommendation.

Recommendation 8: We recommended the St. Louis VA Regional Office Director allocate resources to process special controlled correspondence to ensure timely responses.

St. Louis Response: Concur with recommendation.

Currently, the St. Louis RO has one full time Congressional analyst. From August 2016 – July 2017, an analyst was detailed part-time to assist with processing Congressional inquiries. In May 2017, St. Louis

RO Appeals staff began processing all Appeals-related Congressional queries (based on a review, St. Louis estimates approximately 40% of special controlled correspondence is Appeals-related). The St. Louis RO requests closure of this recommendation.

For accessibility, the format of the original memo has been modified to fit in this document.

Appendix C Office of Inspector General Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Dana Sullivan, Director Daphne Brantley Brett Byrd Lauralee Cook Raymond Jurkiewicz David Pina Michael Stack
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Appendix D Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
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This report is available on our website at www.va.gov/oig.